Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

NUEVA VIDA BEHAVIORAL HEALTH
5555 FREDERICKSBURG RD STE 102
SAN ANTONIO TX 78229

Respondent Name:
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number:
M4-12-1020-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our request for treatment was reviewed and preauthorization was obtained by Zurich. The preauthorization letter determined 'the services described above to be medically necessary'.

Amount in Dispute: $680.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier challenges whether the charges are consistent with applicable fee guidelines. There is a peer review indicating that further treatment would not be medically necessary."

Response Submitted by: Flahive, Ogden & Latson, PO Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2011	CPT Code 97799-CP	$680.00	$680.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, service and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 7, 2011 and November 10, 2011

- W1 – Workers' Compensation jurisdictional fee schedule adjustment.
- 283 – Base on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary.
- As peer adjuster notation this claim is denied as per code W9 peer review.
- No allowance change

Issues

1. Did the requestor obtain preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(10)?
2. Is the requestor entitled to reimbursement?

Findings

Pursuant to 28 Texas Administrative Code §134.600(p)(10) the requestor obtained preauthorization for the Chronic Pain Management program under authorization number 110610-214962-001. The carrier has incorrectly denied the service and payment is recommended in accordance with 134.402(h)(1)(A-B).

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $680.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $680.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 22, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.